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PERSPECTIVES OF ADMINISTRATIVE
AND DIRECT SERVICES PROVIDERS FOR SUBSTANCE ABUSING
WOMEN AND THEIR CHILDREN:
AN EXPLORATORY STUDY

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Susan Gail Lacey
Willem Vanderpauwert
June 1996

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ABSTRACT

Substance abuse by women of child bearing age has been of great concern to physicians, nurses, social workers, child protective services, and drug counselors because it effects two lives. Children born to drug-addicted women in the Inland Empire, increased tenfold during the period 1988-1992. While agencies in The Inland Empire are responsive to the client's needs by legal mandate, the service directives are service delivery are often conflicting in nature.

This research explored experiences and opinions of women and their children. The researchers used face-to-face interviews to collect qualitative rather than quantitative data, which was analyzed by open coding. The unique interaction between the researchers and the participants allowed information to emerge for interpretation and conceptualization.

This post-positivist exploratory study identified the providers' concepts of treatment, the availability of services, agency's achievements and shortcomings, client's needs, gaps and barriers in services, frustrations and unresolved experiences in providing services, and by describing future programs or an ideal program, how the level of funding effected service delivery.

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INTRODUCTION

This research was designed to explore the experiences and opinions of providers in multiple community-based agencies in the Inland Empire. The agencies were providers of direct services for substance abusing perinatal women, their newborn infants and children. These programs served families with children at high risk for physical, sexual, emotional abuse and neglect as a result of their caretakers' substance abuse or addiction.

By definition, perinatal substance abuse is the use of any drug or alcohol that causes harm to women and her infant and/or can be suspected of causing impairment to a woman's ability to parent her children (Model Assessment Protocol, 1991). Understanding and agreement on this definition was essential in our inquiry of service providers. The field of drug addiction and success in treatment has no consistent definitions, making measurements and assessment difficult (Brower-Cohen, Fellows and Lewis, 1992; Reed, 1987).

Recognition of successful drug treatment has seemingly been based on client outcome and rarely done in the area of this research focus, with the service providers view being paramount (Brower-Cohen, Fellows and Lewis, 1992).

When and how to intervene in the drug abusing family has been a matter of controversy for many years. Most Child Welfare agencies believe that there is a nexus between the

mother's drug use and her inability to provide for her baby and her children. In 1989, the Child Fatality Review Panel of New York City recommended that proof of parental substance abuse alone should create a presumption of abuse or neglect, and that the Child Welfare Authority could order parents in reported cases into appropriate treatment. Failure to provide subsequent clean drug tests could result in the removal of the child. But the Inland Empire counties intervene in dissimilar ways, depending on different agency protocols (Bays, 1990).

Problem Statement and Literature Review

Substance abuse by women of childbearing age has had a special status because use during pregnancy effects two lives. Politicians, educators, medical professionals, law enforcement agencies look at federal and local laws about care and services for the drug abusing mother and find conflicting directives to community providers (Maternal, 1992; Brower-Cohen, Fellows and Lewis, 1992; Sager-Ashery, 1995). California legislation mandates the counties to meet needs with a sixteen item list that ranges from respite care to "rehabilitation" of mother and infants (Watson, 1990).

Courts also have ruled that the potential for abuse or neglect, due to the mother's drug use, is enough cause for the baby to be removed, at least on a temporary basis. The Michigan Appeals board wrote that because a child has a

right to be born with a sound mind and body, that maternal drug addiction, leading to drug withdrawal in a newborn, may rightfully be considered child neglect. Thus women who continue to bear drug-affected infants, after they have been advised of the consequences can be prosecuted (Cole, 1990; Bays, 1990).

Proponents of immediate removal of children, view the very fact that the parent used drugs, should result in the removal of the child, believing that this is in the best interest of the child. The mother's drug use prior to the baby's birth is viewed as neglect, and taken into consideration when and how to intervene in the chemically dependent family. It is believed that the problem has become too big and that the large increase in the number of drug abusing families threatens the ability of Child Protective Services to protect the children. Rather than looking into the causes of substance abuse, the severe life stresses that accompany it, the emphasis seems to be focused on punishment of the drug abuser (Anonymous, 1991; Cole, 1990).

Other Child Welfare agencies believe that the responsibility for assuring that children are raised in a safe and nurturing environment, rests with the parents. Only if the parents are unable or unwilling to care for the children should they be removed. Senate Bill 2669 changed the Child Abuse and Neglect Reporting Law to specify that a

positive drug screen at the time of delivery of the infant is not, in and of itself, a sufficient basis for reporting child abuse or neglect. The law requires that, if there is any indication of maternal substance abuse, it will lead to an assessment of the mother and child. The assessment is used to determine if the mother is able to provide the child with regular care, despite her drug use. If it is determined that there is a risk to the child, then a report shall be filed with Child Protective Services.

The recent years have been legislative mandates of service provisions to substance use-related women. Public and private agencies in the Inland Empire have been responsive to client needs as a result of these legal mandates. Studies abound (Anderson, 1993; Sonderegger, 1992; Plasse, 1995) on the success and failure of services based on client participation, abstinence from drugs, babies remaining in the care of their mothers rather than being placed in out-of-home placement and subsequent pregnancies without positive drug screens.

A review of the literature reveals that women's treatment needs are sufficiently different from the treatment currently available for males. Substance abuse treatment originated with male providers for male substance abusers. Recent research advocates for a feminist approach and gender specific needs of the perinatal substance abuser. Awareness of this historical bias helped identify deficits

among prior research (Abbott, 1994; Woodhouse, 1990). Because the participants of this research project were men and women, knowledge of this perspective that the treatment can be male biased was valuable. It is clear that ethics, values and gender-based problems need a different response to achieve client recovery and rebuild families (Carten, 1996; Andrews & Patterson, 1995; Nelson-Zlupko, Kaufman & Dore, 1995).

Recent attention has been focused on community-based outreach and case management services. Family preservation, with its intensive service delivery can be used to motivate the family to seek support from non-abusing friends, relatives and church members, allowing the children to safely remain with their parents. Where the family cannot remain in their community because of deplorable housing or a drug infested neighborhood, residential drug treatment facilities, where women can bring their children, have been successful. Success is measured in terms of client-based outcome and not based on the service providers evaluations and opinions. Many of these studies are positivistic based quantitative analysis (Plasse, 1995; Singer, Bussey, Song & Lunghofer, 1995).

This research project used open and guided interview schedules to survey providers at administrative and direct services levels in the community based practice arena of the Inland Empire. Providers of services are generally not

surveyed about their personal views so much as their programs and service delivery are evaluated and studied according to client success (MacDonald, 1987; Schilit and Gomberg, 1987; CALDATA, 1994). This project explored the provider's perceptions of success and failures in beneficial ways for their profession and themselves.

Currently, San Bernardino and Riverside County Child Protective Services do not have a written policy to address interventions with infants who are born drug exposed. An unwritten policy gives the CPS emergency response social worker direction to not interfere if the drug use does not impair the mother's ability to parent, i.e. if there is no apparent risk to the child, then no protection issue exists. If the infant appears well, and there are no other problems, then the CPS case is closed.

It is generally accepted that it is not the use of drugs, nor the addiction to drugs itself that constitute abuse or neglect to the child, but rather the amount of risk the child is exposed to while the caregiver is on drugs. Thus, a child who is raised by parents who use drugs recreationally is considered to be at minimal risk, while a child raised with a drug addicted mother, whose craving for the child's physical, emotional and medical needs is considered to be at high risk of neglect.

There is a chain of service providers in four categories of statewide agencies: alcohol, drug treatment

and recovery services; family and child welfare services; health care services and lastly, financial services of welfare and medical payments. Our survey interviews encompassed participant providers from the first three categories. The agencies in these three categories emphasize services to strengthen the family. Thus, the mother may enter a drug program, Parenting classes and receive counseling for any underlying psychological problems or get preventative services, while Child Protective Services monitors the case.

Problem Focus

This research study explored and described the experience of treatment services providers for substance-abusing mothers and their newborns. It focused on the experience of providers in public and private agencies. Our choice of the post-positivist paradigm was guided by Strauss's and Corbin's (1990) elaboration that qualitative research seeks answers and theory that are not preconceived, "one does not begin with a theory, then prove it. Rather, one begins with an area of study and what is relevant is allowed to emerge" (p. 23). Post-positivist research allowed actions and answers found in the field to be processed at each interview of a service provider. Tudor (1982) says, and we concur, that post-positivism allows looking for possibilities, recognizing times of congruence

and imbalances when there is interaction between the interviewers and the providers.

Working with the drug-addicted mothers involves the cooperation and the working together of several agencies. The cooperation begins with the CPS referral by the hospital social worker, when a drug affected baby is born, and ends, if everything goes well, with a mother who is capable of providing for her infant. Reduction in the drug use coupled with an increase in Parenting skills, is all that may be accomplished.

While client outcome may point to successful treatment, i.e. the client remains drug free for a set period of time, this study hoped to answer the following questions:

- Did the administrator and the direct service provider differ in their view of success?
- Did the direct service provider become discouraged when the same client re-entered the program again and again because she returned to abusing drugs?
- Thus, while the program might have been successful in helping the client to "kick the habit," what services were needed to prevent the client from relapsing?
- Given the current funding problems for many agencies, are these needed services even feasible?

In order to answer the research question, the positivist paradigm approach with its quantitative methods was rejected as too narrow because it would not allow

exploration of the providers perception and ideas. By using the exploratory post-positivist data, a flexibility and openness was achieved that allowed creative dimensions to arise, without the necessity of providing a hypothesis. The survey interview process and simultaneous analysis of data allowed new knowledge and new theory to emerge (Strauss and Corbin, 1990).

RESEARCH DESIGN AND METHOD

Purpose of the Study

This research study explored the experiences of treatment service providers for substance-abusing mothers and their children. Between 1988 and 1992 the number of drug affected babies, born in San Bernardino County, increased tenfold, from 150 to 1,524, while the number of live births in the county remained constant. This increase brought San Bernardino County to rank fifth among 13 regions in California, in the number of drug affected babies, who require services (Watson, 1990; Perinatal Needs Assessment, 1994).

Providing intervention for the drug-addicted mothers involves the cooperation and the working together of several agencies. Usually a substance abusing mother enters the system because she gives birth to a drug affected baby. This is usually determined by a routine drug test on the

mother, and if the baby shows signs of withdrawal or acute distress, the baby is also tested. The hospital social worker becomes involved by assessing the risk on a perinatal alcohol/drug risk assessment tool. She may make a referral to Child Protective Services (CPS), or refer the client to a perinatal substance abuse program.

In turn, Child Protective Services will make a referral to the Services Targeted on Preventive Program (STOP), and a Public Health Nurse will respond to the home to assess the baby for physical problems and developmental delays. The CPS Emergency Response Social Worker will also respond to the home, and assess whether or not the mother's drug use is interfering with her ability to parent. If Child Protective Services determines that the baby is at risk, and the mother does not voluntarily enter a drug program, the court may order the mother into a drug program and/or remove the child from her custody.

In many cases the mother may have had involvement with several provider agencies that are the target of this research project. It is from this group of providers that this sample was chosen. Because the researchers interviewed an administrator or a supervisor and direct service practitioners at each agency, it was expected that the view of the administrators and the direct service practitioners would differ in many aspects. The administrator could have been more concerned about such things as funding and costs

of the program, while the practitioner might have been more concerned about his or her relationship to the agency and the client and the progress, or lack of progress, the client makes in the program.

Research Question

The research question explored providers perception of the services they give to substance-abusing women: Do views differ between those who are in administrative roles and those in direct services? Is relapse a discouragement? Does funding hamper service delivery?

While previous research translated behavior into quantifiable data, the present research accessed service providers' experiences with recovery programs but used a post-positivist paradigm and qualitative grounded theory. Grounded theory is the systematic technique of observation, comparisons and interpretation done by researchers in direct, personal, field contacts (Rubin and Babbie, 1993; Strauss and Corbin, 1990). The personal qualities of the researchers allowed development of rapport and acceptance with individual participants. Degrees of theoretical sensitivity separated pertinent data, stimulated the exchange of information, gave insight, and subtle awareness of participants. To achieve accurate data, the researchers also maintained a self-awareness of their views, bias and agenda in relationship to the research focus.

The researchers were experienced and seasoned service providers within Mental Health and the Children's Protective Services systems, specifically the Child Welfare aspects of substance abusing perinatal dyads. Their desire was to explore the realities of other professional providers' experiences and gain ideas of comprehensive services to a special population.

Sampling

The sample used in this study was chosen from providers of services to drug affected babies and their mothers. This included public agencies such as CPS, STOP, perinatal substance abuse programs and private drug rehabilitation and recovery treatment services. The researchers interviewed an administrator or supervisor and direct services practitioner at each agency. A total of fifteen interviews were completed. It was a sample of convenience rather than a random sample of providers, based on their geographical location in the Inland Empire.

Data Collection and Instrument

For exploratory purposes this project used an interview guide instrument. Attention was given to the format so items were open ended, simple, non-threatening and allowed the participants to use their own frame of reference (Becerra and Zambrano, 1985). The researchers met

individually with the participants in face-to-face interviews, using the interview guide as a prompter to get a sample range of provider experiences.

Grounded theory uses observations, answers of participants and constant comparisons in the hope of generating new insights (Rubin and Babbie, 1993). The choice of measuring instrument was made to provide flexibility and allow adaptation of wording and question sequences for the individual interviews.

The researchers developed an original list of initial questions to be asked of participants (see Interview Focus Instrument, Appendix A). The exploration will focus on eight areas: 1) Who are the providers, administrators and direct service practitioners; 2) Who are their clients and their demographics; 3) Provider agency goals; 4) Providers view of those goals; 5) View of achievements and shortcomings; 6) Providers' view of client needs, availability in their respective programs; 7) Frustrations and unresolved experiences; 8) Providers' suggestions for future program services.

Procedure

Data was collected at public and private service agencies for substance abusing women in the Inland Empire, in the Spring of 1996, at the administrative and direct services levels. The data was gathered using a grounded

theory system of exploratory interviews and observations. After initial rapport was built with the service providers, the researchers used the interview guide instrument and additional open ended questions in response to the material presented by the participants. Fifteen participants were interviewed at their place of employment in single face-to-face interviews, lasting from about 25 minutes to 90 minutes in length.

Notes were taken during the interview and audio tape recordings were made for reference. Latitude and variance were noted between each interview, so the detailed notes were essential and the audio tape was used to check accuracy.

Protection of Human Subjects

The researchers protected the identity and the anonymity of the participants in this study. Individual responses were coded by number rather than by name, and any identifying data was kept separate from the responses. Each participant was given a brief explanation of the purpose and the goal of this research project. Participation in this study was voluntary and each participant signed an informed consent form (Appendix B). Each participant was debriefed immediately after the completion of the interview and were given the names and the phone numbers of the researchers and the faculty advisor, in case any problems arose (see

Debriefing Statement, Appendix C).

Data Analysis

These researchers used the Grounded Theory approach, as described by Strauss and Corbin (1990), to analyze the qualitative data collected from perinatal substance abuse service providers. Primarily open coding was used throughout this analysis because of its usefulness in discovery and categorization of the phenomena under investigation. Open coding made possible the identification of not only categories, but also their properties and their dimension range. The identified major themes provided focus, while subsequent interviews supplied recognition of similar properties and range. There was integration of the provider interviews and the open coding analysis on a continuous basis throughout the research project.

In addition, the researchers gathered demographics including the type of client served by the agency, their gender, ethnic origin, marital status and so on, and the type of services provided by each agency. Demographic information collected on the agency and its employees was similarly gathered.

Each of the participants was interviewed by one of the researchers. The interview guide was used to start the interview process. Subsequent questions asked were determined by the participants responses, and the insight

the researchers gained from the prior interviews. The researchers' notes and the tape recording of the interviews comprised the raw data. The interviews were transcribed and all data analysis was done with the researchers working together.

Each interview question was initially analyzed individually. The key point in each question became an anchor in the data analysis. Concepts from each question were identified on note cards. The responses from all the participants were discussed and compared. Similar responses were grouped together. Categories emerged as themes became apparent across the participants responses. The frequency of the responses was determined by counting how many participants responded in a similar way to a question.

RESULTS

Demographics

Fifteen participants were interviewed for this research project. They were all professionals in the Inland Empire of Southern California. Demographic data included each participant's employment function, years of education, professional degree, years of experience in their field and with their present agency.

Most participants estimated the demographics of their clientele in areas of gender, age, ethnic origin, marital

status, number and ages of their children and finally the substances abused. There was no intention of this data to be scientifically accurate and is a representation of the participant's view only.

Throughout this discussion the participants are described as counselors, therapists, social workers and nurses. It is to be understood all those interviewed were professionals and there was no intention to imply status or different value in any of the terms used as some are used interchangeably.

Question 1: What is your function in this agency?

Some of the fifteen participants reported themselves to have multiple agency functions. Two considered themselves administrators; there were seven supervisors, and thirteen direct services practitioners. Two counselors reported that they had all three responsibilities. There were five male participants and ten were female. Their ages ranged from 32 to 64 years. The mean age was 47.5 years. There were three in their thirties, six in their forties, five in their fifties and one in the middle sixties.

These counselors were very well educated: all had college educations with only one having less than a bachelors degree. Six stated they had at least masters degrees; there was one doctorate and two doctoral candidates. Educational degrees included five Masters of Social Work, four MFCC's, three Nursing degrees and three

counselors in drug and alcohol studies. Experiences among the participants in their current agencies ranged from one with two years, six with three years, to two persons with twenty years. The mean number of years was 6.9 years; the median was 9 years. The fifteen had been in their chosen field from three to twenty-eight years. There was a total of 172 years and an average of 11.46 years and the median of 10 years.

Question 2: Who are your clients?

Client demographics fell in six areas: gender, age, ethnic origin, current marital status, number and ages of their children and lastly, the substances they abused. Eight participants estimated their answers in all six categories, while seven did not answer this question. Two counselors dealt only with female clients and two reported to have caseload consisting of 30% female clients. The males ranged from 70% to 25% of clients served. While female clients were as young as twelve years old, the youngest males served were fourteen. Both genders were served into their 70's. The ethnic origins are reported on the following table.

Participants Estimates of Client Ethnicity
by Caseload

Number	Caucasian	Percentage
3		70
1		60
4		40
<hr/>		
	Hispanic	
3		30
5		20
<hr/>		
	African-American	
1		40
1		20
5		10
<hr/>		
	Asian, Native American, Other	
3		10-20
<hr/>		
N=8		

Most participants reported their clients to be either single or divorced. The third most mentioned marital status was "Living with a significant other." The number of children in the household ranged from twelve to none. The ages of those children ranged from infancy to adulthood.

The substances abused by these clients group in very few areas: methamphetamines, heroin, alcohol, cocaine, marijuana, prescriptions, and those who are polysubstance abusers. Seven participants answered this question saying they work most with crystal methamphetamine abusers. One counselor identified alcohol as most common. Cocaine and marijuana were mentioned second, two times; heroin was third, four times. Polysubstance abusers use alcohol or marijuana with speed (methamphetamines). The poly users are usually under thirty-five years of age. Participants

mentioned the method of use progresses from smoking, intravenous use, to inhaling and snorting.

Findings

Question 3A: What services are available at your agency?

Services available in the participant agencies had the following properties and a wide dimensional range: (Number of respondents in parentheses)

Case Management Services (9) - Family Maintenance, Family Reunification, Monitoring and Referrals, Assessment, Networking and Vouchers for Immediate Needs.

Outpatient Services (7) - Individual, Couple and Family Counseling, Substance-Abuse Counseling, Perinatal Services, Crisis Intervention, Methadone Maintenance, HIV-testing, Adolescent Outreach.

Inpatient Services (3) - Detoxification, Dual-Diagnoses patients, Rehabilitation.

Residential Services (3) - Social, Modified-Medical Model Drug Treatment, Parenting classes, Chiropractic, Dental Care, Group and Individual Therapy, Social Skills, Adolescent Unit.

One participant has research services for treatment models and medication and trains other professionals.

All fifteen participants responded to having short term and long term agency goals. Everyone stressed that the intervention should be by the least intrusive methods with

special consideration of ethnic and cultural issues.

Question 3B: What are the goals of your agency, long term and short term?

There were twenty responses classified as long term goals. The most frequent (6) was providing services to help clients in their homes. These goals ranged from outpatient care, stabilization, maintenance and improvement of client situations, so safety issues were resolved and children were not removed. The second most cited goal (4) was prevention of abuse and the protection of children. The third goal cited dealt with factors of drug use. This ranged from expecting sober living and being drug free to the identification of the parental drug problem. Teaching clients, tutoring and literacy concerns were mentioned as long term goals two times. Five other agency goals were mentioned once each to offer multiple treatment options, to have a community medical center, the need for lifestyle changes, family reunification and quicker permanency planning for children.

Participants reported their agencies had fourteen short term goals. The goals were generalized in four categories. First (6) was the necessity to provide protection, safety and for the immediate needs of clients and their children. This was accomplished by doing assessments, making referrals, and providing family maintenance services. The second goal (3) was reunification of minors with their drug

abusing parents. Four respondents felt the provision or referral to drug recovery, relapse prevention and/or abstinence was their third goal. The fourth mentioned goal (2) was response to all referrals received and providing crisis and preventative services. Three goals were mentioned once each: to make the least intrusive interventions, to provide adolescent services, and to increase and teach clients new or improved social skills.

Question 4: What is your view of the agency goals?

There were thirty responses to this question. The category most often mentioned (2) dealt with the ineffectiveness of the services provided. Of those (6) viewed the services as ineffective because they were voluntary. Without constant monitoring, or "a push," the client would not do anything. Other responses (4) were that the agency did "bandaid work" and that the client often failed to follow through on referrals made or had poor attendance when they went for services. Clients were often seen as providing "lip service," by telling the worker that they were in treatment, but in reality were not. Two stated that the main issues or the underlying causes of the drug use are often denied or avoided by the clients. Two respondents felt that Family Reunification was too difficult to achieve for the drug abusing family and preferred Family Maintenance as a service approach. One respondent felt that parents cannot protect or provide their children with their

basic needs regardless of services offered.

The second category related to timing, schedules and case management; there were five responses. Four responses were that cases were closed too fast and there was not enough time to help families develop lasting skills. One respondent felt overwhelmed by the agency's tasks and requirements, and that never ending paperwork takes away from time to help the family.

The third category dealt with needs. There were five (5) responses. One commented that sometimes it is difficult to keep the focus clear; the law dictates what can and cannot be done, versus making value judgments. One respondent wanted more clout, others (2) wanted more money for their agencies. The treatment dollars are changing and the rise in managed care requires negotiating with a third party. Another respondent felt that a bigger outpatient department would increase the effectiveness of the agency.

The fourth category dealt with the positive feelings for the agency goals. There were four (4) responses. Their agency standards were admired. Their agency was grounded. Their agency was doing a good job. The respondent expressed positive feelings.

The fifth category related to how services were being provided. There were six (6) responses. There was a wide range of how child welfare agencies should respond to the drug abusing mothers and their families. Either they did

not respond fast enough in removing children or did so only in the most severe cases, or they waited until the situation became too severe to allow the child to remain at home.

There was also disagreement by two respondents on whether or not Family Preservation should be used more extensively as a service modality in the future.

Two responses addressed a need to start looking at new methods of treating the drug addict, or to aid in prevention the community should be better informed and educated regarding drug abuse problems.

Question 5a: What are the agency's achievements?

There were a total of 35 responses. Eight responses dealt with the quality of services being offered. Responses in this category included: We protect children and we do so by using methods that are effective; the goals of the agency are good; there is positive energy, the agency has good intentions, but goals are not achieved or only partially achieved; goals are complete and the agency offers quality services.

The second category, with six responses, dealt with agency policy. Responses included: intervention had changed to a multi-level of care; the agency had gone from six months intensive clinical services to integrative and long term care, gradually tapering off the client's visits. When a case moves from Emergency Response and Family Maintenance to Family Reunification and Permanency Planning,

the rights of the parents become less important and the rights of the child become paramount, was seen as an important factor in Child Welfare Services. A fourth response said the services did have an impact, which was not necessarily noticed by the public.

The third category with 5 responses dealt with mandates and coercion. These respondents felt that clients will not volunteer for services and need to be court ordered into services. Related to this is the role CPS plays as "the enforcer," clients are threatened with a referral to CPS, or the removal of their children if no changes are made.

The fourth category dealt with long term achievements (3). They were clustered around how the services available could help the client achieve long term sobriety, provide the client with at least six months services, and the agency was able to offer stabilization and integration.

The fifth category dealt with early intervention (3). Early intervention was seen as more effective and was needed before the client becomes a heavy drug user or addict. Parenting classes and brief interventions were also seen as being needed during the early stages.

The sixth category dealt with making small family changes. This was emphasized by two respondents. A third respondent stated that mother's need to learn how to deal with simple things, as how to take care of a stuffy nose, and how regular check ups and well-baby care give babies a

better chance in life.

The seventh category dealt with staff issues (2). Staff members were seen as dedicated and the staff continued to educate themselves.

The eighth category dealt with services. There were a total of eight responses, none mentioned more than once. They included: Dual disorder treatment; parent education; STOP; a new program for the Correctional Institute for Women (CIW) for twelve parolees and a one year stay at Forever Free; a training ground for interns and national accreditation for three years. Another service achievement was the adopting out or providing legal guardianship for medically fragile children, and the role the agency played in protecting these children.

Question 5b: What are your agency's shortcomings?

There were a total of 46 responses to this question. The category with the most responses (13) dealt with lifestyle issues. The responses clustered on issues of the client's unwillingness to participate in a program or to receive services; intergenerational and underlying problems not being addressed and other family and social issues the agency or agencies cannot do anything about and peripheral issues needing to be resolved. Other problems were how to deal with client's peers who continue to abuse drugs and effect client outcome or the client's need being too great and the agency having unclear expectations. One respondent

stated foster parents get lots of training in how to care for the drug-affected babies or medically fragile child, while the parent is offered none. Clients also needed more home-management skills and positive Parenting models.

The second category with seven responses, dealt with time issues. The respondents (3) thought cases were being closed too fast due to agency policy because the time frame to provide services had expired. This resulted in many cases coming back over and over again, often with the same problem. Two respondents stated the agency's expectations were too high, and it was impossible to make lasting changes in the family in short periods of time. Clients with a dual diagnoses, drug abuse and an emotional problem, often need more than six months of treatment. One county will pay for sixty days maximum for drug treatment. Follow up is important, the client needs to return if she continues to use drugs, even if everything else seems to be going all right.

The third category involved political statements (8). They included: the lack of support and involvement of the community; society being out of control; lack of focus on the main issue in society - to stop drugs; political game playing between Mental Health and the Office of Alcohol and Drug Abuse Problems. Another respondent noted the double standard - functional parent versus non-functional parent, and who gets caught. Society does not seem to value the

work, as expressed in the low wages being paid.

Question 6a: What is your view of the client's needs?

The first category clustered around service needs. There were 13 responses. Clients need rehabilitation, and support. Two respondents wanted to "pick up" and place the whole family. Mothers and children should be seen together and (3) wanted residential care that included children and fathers. Shelters that would take boys over 10 years old were also needed. Better counseling and psychiatric care were also mentioned.

The second category dealt with practical needs. These needs included: services to learn budgeting, how to deal with HMO's and welfare, Parenting classes and home management skills. Legal aid, employment and transportation were also included.

The third category clustered around root causes (4). Lack of appropriate parenting role models and intergenerational drug use were mentioned two times. The client's intergenerational lifestyle was seen as a hindrance to solve their problems.

The fourth category dealt with community interaction. There were four responses. They included: Planning needs to include other agencies and collaborative arrangements are necessary. The problems are not just agency problems, they also involve the community.

The fifth category clustered around the need to stop

the substance abuse (4). There is a need for a safe and drug-free environment. Substance abusers are often in denial of the problem; the need to look at the nature of substance abuse, which negates anything voluntary.

The sixth category, with four responses, did not have a clear theme. They clustered around the respondent feeling unable to meet all the needs of the client, due to limited involvement. Perinatal program's success seems to be shorter ranged. If the case goes to court, too much is judged on appearance.

The seventh category dealt with monitoring. There were five responses. Clients need longer monitoring. Parenting skills needed to be observed on a twenty-four hour basis, and intervention should be based on observation rather than the interpretation of the event by the client. Clients also need at least two years in a controlled setting. Workers should not rely on several negative drug screens as a predictor of success.

The eighth category dealt with when to start services (3). Timing was seen as important as to when services were to start. Mothers are more willing to start a program after giving birth, when the mother often experiences guilt, and may motivate her into a program.

Question 6b: Does your agency achieve your view of the clients needs?

There were 14 responses. The most frequent responses

(5) involved the use of court action. Some respondents blamed the law for preventing true protection of children from parental drug use because the parents' civil rights are protected or the courts return the children before rehabilitation is complete. On the other hand, some court action can activate or shock parents into counseling and would only have shown this willingness if their children were removed. Two respondents said we have plenty of resources in the community, two participants said their agency can meet their goals with good counseling, while two said their goals are rarely met in their agencies. There was one reply each that we can provide the structure to meet goals if we check on clients more often and use community resources appropriately.

Question 6c: Are there any barriers and gaps in services provided?

There were 16 responses to the question concerning gaps and service barriers in services that need changing to meet their view of client needs. There were sixteen mentions within the agencies concerning organizational or logistical problems. These included lack of, or barriers to, services for illegal immigrants (2); residential and shelter care placements for parents and their children, primarily missing are places for older boys (2); problems in location and transportation to services (3); waiting lists (3); the need of more educational services to benefit staff and clients

(1); and one mention each of barriers because of caseload size, lack of funds, and too few long term programs. There was mention that one agency needed some consciousness raising about "what we do and for whom" we provide services.

Another group of barriers within the agencies were clinical issues of the providers not wanting to be seen as an enabler (2), the nature of the drug use is denial and this is not dealt with or understood (4) when services planned. Therapy issues of co-dependency, mood swings, family recovery and crisis management need more attention (4). Others (5) mentioned drug rehabilitation and CPS being punitive because they are court ordered. This punitive view causes parental anger (2) requiring skilled service providers who can work with the client's resistance and start where the client is.

Gaps in agency success with the participant's view of goals grouped in complaints of court actions and failures in drug rehabilitation issues. Court (6) was cited as adversarial, making quick returns, parents having too many rights and not using more leverage. Rehabilitation does not get to the core issues in time allotted.

Gaps seemed evident because services don't communicate (4) effectively, while one participant praised the separate services through contract agencies and wanted more because parents will cooperate more fully with the agency who is not punitive, i.e. threatening to take custody of the children.

Question 6d: Are there any services that clients need, but are not available from you or others?

There were 32 responses to service needs. The tangible services grouped into things agencies do well but never have enough of or need higher quality: money (3); housekeeping and home management skills (3); residential (3) and foster care placements (1); "good" therapists (1); parenting and anger management classes (4). Insurance, transportation, clothing, utilities and better support systems were mentioned once each.

Clinically-centered service issues (4) were the need for longer time frames for success, utilization only if monitored, and long waiting lists. Two respondents acknowledged resources from other entities were valuable: Department of Vocational Rehabilitation (DVR) and the Office of Alcohol and Drug Programs.

Four mentioned a concept in our counties, but not available locally: HOPE and Families First, where clients are given intense daily services by multiple agencies to improve their functioning.

Question 7: Are there any frustrations or unresolved experiences in your efforts to provide services to your client?

There were 49 responses. The frustration reported as unsolvable by the respondents, grouped in client focus, social worker/counselor focus and legal issues. Eleven said

that clients escape, don't follow through, and have repeated referrals because no one can force responsibility to the extent they comprehend the seriousness of their disease or the loss of their children. There were ten replies citing diagnoses and behavior that hamper client functioning and compliance: obsessive-compulsiveness, paranoia, propensity to violence, low frustration tolerance, denial, rationalization, self-destructiveness, and staying in domestically dangerous situations. Clients' reality (5) is such that lifestyle, community and intergenerational patterns are ingrained, unchangeable and beyond outside control, no matter what professionals have to offer. Legal experiences lead respondents (5) to be unhappy about prenatal drug use, too many chances allowed and no criminal prosecution for drug use.

Counselors frustrations focused on the perception clients blame others for their failures (3) and that their low functioning causes them to see the "helpers" as punishers and persecutors while they are in denial about their role in failure. Some (3) mentioned burnout, poor sharing of information and work with other professionals and a need to revise the welfare system (2) so it does not reward women for having subsequent drug-affected babies.

Seven services were cited as decreasing or non-existent, that caused frustration to service providers: general funding cuts (5); services to special needs and

developmentally disabled families; outreach; PHN's, 24 hour services; managed care supplanting long term contracts; and no functional Family Preservation plans, were mentioned once each.

Question 8a: Are there any future programs being considered?

There were 20 responses. The service providers, administrators and supervisors told of future programs being considered. Eleven prescribed project HOPE or Families First concepts with trained professional and paraprofessionals and daily contacts made in the homes of the substance abusers, to give real "Family Preservation Services." They also saw an increase in perinatal (3) programs, an expansion of foster and adoptive home support groups (2). One each looked forward to more outpatient care for drug users and better drunk driving programs.

Question 8b: Use your imagination and make suggestions about an ideal program?

There were 31 responses. Answers (8) were complaints about present services delivery to drug-affected families, particularly from Welfare. Suggestions were made that parents work for funds, decreasing rates with new births, tie school attendance of all age children to receiving money. Positively, incentives (2) should be offered for drug rehabilitation, perinatal services accessed and successfully completed.

Positive programs (7) suggested were for prevention, proactive education, role models, better clinical screening and screening assessment instruments, and centralized all inclusive service centers.

The drug-affected infants were a concern (4) for assessment at birth and at the time pregnancy is discovered. There was a suggestion all drug-affected newborns be removed as a logical consequence and placed for potential adoption.

The last imagination program was modeled on a kibbutz (5) with 24 hour shelter provided for parents and children to improve parenting skills, to alter lifestyles and access underlying causes of drug use.

There were eight miscellaneous suggestions: situation is not hopeless; we are lucky to have current funding, so get on with the programs we now have; better education for all providers; have smaller caseloads to provide intense, weekly contact and follow ups.

DISCUSSION

While the researchers expected to find a difference in the perception of administrators, supervisors and direct service providers concerning the services that their agency provided, there was little or no difference found. Supervisors had a tendency to expand or clarify the information already obtained from the direct service

providers. The researchers noticed early in the interviewing process that results and comments from administrators and direct service providers were not going to be different according to their employment classification.

The researchers found the respondents' became discouraged when the same client re-entered their program again and again, due to relapse. Their discouragement was tied to perceptions of ineffectiveness. There was a dichotomy in the client versus provider view of who was ultimately responsible for treatment success. The client and the community had the expectation that providers of drug services would effect the difference or the cure. The respondents recognized differences and improvement came from the client's work. Mentioned repeatedly was the failure to treat underlying issues and root causes of drug use. Some of the ineffectiveness was attributed to lack of community involvement and the general public's attitude of "let someone else do it."

Demographically the ethnicity of the population of the Inland Empire parallels that of the ethnicity of drug abusing clientele seen by the respondents. There are 70% Caucasians, 30% Hispanics and 20% African Americans in this area. Likewise, the drug of choice fits the demographics of the Inland Empire. San Bernardino County, is known as the "speed capital" of the United States and heroin use is

increasing among Caucasians and Hispanics. The respondents said they see methamphetamine and heroin users most, with polysubstance abusers primarily among the African American population. Thus, the respondents, linked drug of choice to ethnicity. A similar link was reported in the CALDATA report (CALDATA, 1994).

All participants stressed their interventions used the least intrusive methods to reach long and short term treatment goals. Private and public agencies wanted clients to receive services on an outpatient basis, while they remained at home. These outpatient goals prevented splitting families and provided protection, safety and for the immediate needs of the client and children. If services in the home environment were unsuccessful, then all providers felt that those programs that included children, or early reunification of children were most desirable. If these services failed, family reunification, permanency planning and adoption were to proceed in the best interest of the child rather than the continuing concern of the parents' rights.

Respondents mentioned the ineffectiveness of current provision of services twenty times. The goals were perceived as having allowed the client to avoid the underlying causes and root issues. The root issue of drug abuse problems was considered to be denial. As clients continued giving "lip service" and avoided the extent of

their drug problem, no matter how much monitoring and "pushing" the providers did, the clients continued to relapse. Therefore the agencies did what they perceived to be as "bandaid work" by providing referrals to already overloaded and inaccessible resources. While clients were sent to fragmented services, the respondents worked in agencies that were fragmented with schedules, timing and tasks that became overwhelming.

Participants reported that there were shortcomings in how the agency achieved what they viewed as the agency's goals. Most of the responses clustered around their clients' lifestyles and their unwillingness to participate in the treatment plan. The respondents state that being drug addicted focuses the client's attention on obtaining and using drugs, everything else, including caring and providing for their children, becomes secondary. Amphetamines and methamphetamine users will stay up for days, then may sleep for several days. The cycle is often repeated over and over, leading to neglect of their children (Bays, 1990).

A few of the participants saw themselves as "change agents" and felt overwhelmed by the time limits placed on them by their agency. These workers wondered how they could accomplish anything in the little time they had to work with the client. The agency's policies on client contact requirements or the high caseloads were blamed for not

meeting the goals. They also felt that cases were closed too fast and that there was no time to build a working relationship with a client who views the CPS services as being involuntary and punitive.

When the court was involved, the legal system was seen as too adversarial. The key issues was parental rights versus the rights of the children. The social workers felt hampered by the client's attorney instructing the client not to discuss the allegations against them, with the social worker, limiting the workers effectiveness in formulating a treatment plan. Participants were equally frustrated when the court returned children against their recommendations. When the goal of the agency was seen as protecting children, the parents lack of involvement often did not matter. After twelve months the case was referred to permanency planning, and the parents written off. While Family Reunification must be offered, does the present system allow the social worker to work just minimally with the parents? Or is this how the social worker copes with the frustration of the high caseloads? The participants in this study, rather than focusing on the client's strengths, focused on the client's weaknesses and by doing so, became overwhelmed by the same feeling of helplessness, experienced by the client.

Participants identified several needs their clients had but were unavailable, in short supply, or the quality of the available services was in question. Because lifestyle

issues were seen as a major barrier to providing services, it is not surprising that such basic skills as how to clean house and home management were relatively high on the list of needs. Neglect, not providing for their children's basic needs or not cleaning the residence are often seen in drug addicted families. CPS social workers refer to lifestyle issues when they are intergenerational. These clients have not learned how to properly clean a house, and have no idea what is expected when they are told to clean up. Workers need to start "where the client is at," if they are going to have an impact on the client. What may be perceived as resistance may, in actuality, be a lack of knowledge.

Budgeting also was a problem. While addicted, the client used her income, the welfare check and food stamps to buy drugs. Utility bills, rent and other needed services were often not paid. After leaving the drug program, the problem becomes how to make the money last, or the cycle of neglect will be repeated. The participants also saw these issues as leading to much of the frustration they felt dealing with these clients.

Needed also was residential care where the mother can bring her children. Residential care may be the answer when services are not available or clients do not have a way of getting there. Barth (1994) advocated that residential care be used as an alternative to Family Preservation when families cannot stay at their dilapidated residence or when

it is located in a drug infested area and staying there would interfere with their recovery. He referred to this as shared care because the parent, while in residential care would continue to have responsibility for the children. Some of the respondents in this study pointed to teaching parenting skills in similar settings. Learning parenting skills without the children being involved does not make sense, they need to practice and learn what will or will not work with their children. Relying on client report versus direct observation by the worker, was seen as less effective and the client would benefit more from the worker's feedback of what was observed.

Based on the frequency of responses, participants generated the most statements with 49 identifiable concerns about frustrations or unresolved experiences in their efforts to provide client services. There was no hesitation in the respondents recognizing and sharing frustrations of their roles as direct service providers to the drug abusing population of the Inland Empire. The predominant focus concerned clients, not the agencies where people work. Much related to characteristics of a substance-abusing pathology that gives recognition for clients' psychiatric diagnoses and disability. Paranoia, denial, compulsion, dependency, self-destructiveness are the essential features of substance dependence (DSM-IV, 1994). To have the desire to cut down or quit drug use while spending more time obtaining the

substances also frustrates providers. They are interacting to the elements of dependence and despite theoretical knowledge of substance dependency, they expect clients to comprehend and make rational decisions about life and their children. The providers react with the typical anger and search for solutions to the disease. There was acknowledgement (5) that client recovery effects the lifestyle, community and society structure beyond any influence of current services.

Inability to understand the realities or being too long in the thankless role of "helper" has resulted in "burnout" for some, while others still seek causes and cures in an apparent effort to make the multi-faceted diagnoses simple. In this effort the providers do some blaming of courts, welfare and funding cuts. Some took a punitive stance of clients needing more criminal prosecution and fewer chances at becoming responsible parents/citizens. We saw providers recognition of ineffectiveness despite all their best efforts. Decreases in tangible/material resources caused frustration whether in funding, specialized programs or the appearance of major revisions in services under managed care contracts.

The area of substantive services contained dreams and ideas of future programs. The service providers tackle planning for the future based on success they have seen elsewhere. Mentioned most often is the concept of intensive

interventions reaching into the household of the substance abuser by professionals from multi-disciplines mitigating risk to babies and children. The Families First or HOPE concepts intervene in the home of the client in crisis with counseling and practical services. At a stabilization point advocacy for competent community services has a higher expectation of success in the view of local providers. Community services all need expansion whether they specialized for dual diagnoses, perinatal, outpatient parenting, or drunk driving and domestic abuse programs.

Private and public agency provider respondents suggested that improvements could be found in screening assessment tools, preventive and proactive education in the community and finally a move to centralized all-inclusive service sites. Some wanted shelters where the entire family can live in the treatment center away from the immediate environment that promoted drug use. Alternative treatments use teams to incorporate the disciplines of mental health, social services, drug treatment, finances and nutrition. Nelson-Zlupko et al (1995) verified this as a positive model for the substance abusing woman saying, they need help for guilt, shame, depression, and anxiety. There was a realization women are the primary caretakers of children even while abusing drugs, so the child's inclusion in successful programs is essential.

Nelson-Zlupko et al (1995) hold insurmountable stress

as the barrier women are trying to cope with when drugs are used. This supports our respondents' suggestions that the future holds alternatives in treatment that focus on outreach, positive, coping strategies and overcoming environmental influences, not in punitive judgmental ways of past practice (Tracey, 1994; Plasse, 1995). Not only were court-ordered male oriented treatment models ineffective with the substance abusing woman, they violate the fundamental ethic that says recovery and help should be done in the least intrusive environment, i.e., their own homes, with the whole family and include social plus economic needs (Andrews and Patterson, 1995; Azzi-Lessing and Olsen, 1996). We know successful future programs should not separate families if we hold to child welfare mandates and public opinion that families are the best caregivers (Tracey, 1994; Barth, 1994) whether in their homes or group treatment facilities.

Pooling all responses across categories and questions saw common themes emerge: money; quality of parenting or lack of parenting skills; root issues and intergenerational focus; availability of services and their limits. A consideration of each of these seems important.

First, the theme of money spans the positive feeling we should use what we have to better effects (2). While on the opposite side, complaints (8) that increased money could mean success and provide services, manpower and "the clout"

to effect positive changes to substance abuse programs. These responses were given as part of agency goals, agency shortcomings, participant frustrations and suggestions for ideal programs.

Concern about basic root issues of heredity, environment, bonding, psychosocial development and a disruption in any of these for parent and child was found in responses from five questions. These were linked to limited chances of success unless primary difficulties were addressed. Lifestyle changes parenting and life skills enhancement were repeatedly identified as necessary but rarely tackled service because of time and money. Resources necessary to break through denial of client addiction or failure to go below surface concerns means the clients reappear over and over (Plasse, 1995; Andrews & Patterson, 1995). Tackling lifestyles, values and teaching parenting, relapse prevention, can be the keys but are resisted when our country holds personal rights and choice in high regard. The choice to self-destruct goes against some of our ethics while social work holds client self-determination and choice as paramount.

One of the themes which appeared across numerous questions was that of agency resources. Examining the responses about resources and services available in their agencies showed services spread from outpatient to case management. In the query of barriers and gaps - resources,

or the lack of them, was the largest complaint. The future programs, as envisioned by respondents, were expansions of present services. Combining participant lists of services available in their agencies, their view of services clients need and proposed programs, the responses totaled 75. Obviously there are services in the Inland Empire, but do those who could use them know about them? Do the professionals know and access the services in the community, outside their personal agencies? Private treatment and child welfare sectors are not linked to the advantaged of their clients, the substance abuser and their families (Azzi-Lessing and Olsen, 1996). Public and private sectors need to develop greater expertise, awareness and cooperation with each other. They need collaboration training to realize their dreams for better services to their mutual clientele.

IMPLICATIONS FOR SOCIAL WORK PRACTICE

This was an exploratory study. The sample was one of convenience rather than a random sample. Generalizations to other treatment agencies for drug affected women and their children, cannot be made from this study. Implications from this study point to a need to better train workers in dealing with the drug-addicted families. The participants responded overwhelmingly that they were frustrated with the

clients re-entering treatment again and again, while their discouragement was tied to the perception of service ineffectiveness. Workers got "swallowed up" by the clients denial of the problem and responded with helplessness which reinforced their feelings of ineffectiveness. They sincerely believed that nothing could be done for the client, which resulted in a focus on client weaknesses rather than strengths. If workers are going to be successful they have to learn how to assess for strengths. The client has probably heard from everybody else that they are "good-for-nothing." They do not need a therapist, counselor or social worker who is going to tell them the same.

These clients need to learn how to work effectively with the agencies, while workers need to learn how to make effective referrals. There seemed to be an incongruence between availability of services and the participants knowledge about these services. Participants mentioned that their agencies did referrals, were also the ones that felt most frustrated with the clients lack of follow-up. These researchers learned that the agencies providing drug rehab services were comprehensive. Yet, others complained of a lack of these services. Agencies need to better educate each other about the availability of services and how these are accessed. Because of negative experiences with helping professions in the past, clients may need to be escorted to

a new agency and be introduced to the staff and overcome that initial fear of anxiety that stops them from making the connection.

Workers also need to realize that they have limitations, and referrals should be made when the client's needs are beyond the worker's expertise. There are many agencies that specialize in treating drug addiction, self-help groups, and so on, that can help.

Drug abuse involves all family members and treatment should be family-centered. When family reunification is ordered, the worker should at least attempt to work with the family. After detoxification, whether medical or social, dealing with the underlying issues is paramount. Clients are more likely to cease using drugs if they have an alternative way of coping with the emotional pain that so often leads to drug use.

The findings warrant further research. This study involved a majority of participants from child welfare agencies in the Inland Empire, which may have contributed to the large number of responses of perceived ineffectiveness. Because the sample was not random, findings may not have been representative of direct service providers as a whole, but may have occurred by chance. Further research may be able to shed more light on this finding.

APPENDIX A

Interview Focus Instrument

1. What is your function in this agency?

Administrators

Supervisors

Direct Service Practitioners

Gender: M F

Age: _____ years

Education: 12 14 16 +years

Degree: Social Worker Nurse Counselor

Years of experience in your field _____

Years of experience in your present agency _____

2. Who are your clients?

What are their demographics?

Gender: M F

Age: _____ to _____ years

Ethnic origin:

Marital Status: S M D Living With

Children: Number _____ Ages _____

Substances abused:

3. What services are available at this agency?

Outpatient Inpatient Residential

Detoxification Methodone Maintenance Perinatal

Case Management

What are the goals of this agency?

Long term?

Short term?

4. Your view of agency goals:

5. What are the agency's achievements? Any shortcomings?

6. Your view of the client's needs?

Does the agency achieve these?

Are there barriers and gaps in services provided?

Any services that clients need, but are not available from you or other?

7. Are there any frustrations or unresolved experiences in your efforts to provide services to your clients?

8. Are there any future programs being considered? If not, use your imagination and make suggestions about an ideal program.

APPENDIX B

Informed Consent

The study in which you are being asked to participate is designed as an exploratory investigation of direct services to substance abusing women and their children in San Bernardino County, from the view of the service provider. Administrators and direct service practitioners of agencies, public and private, in the West End, and the city of San Bernardino will be included. This study is being conducted by Susan Lacey and Willem Vanderpauwert, graduate students in Social Work at California State University, San Bernardino. This study will be supervised by Dr. Marge Hunt, professor of Social Work.

In this study, Susan Lacey or Willem Vanderpauwert will be asking you a series of questions designed to get the experiences, attitudes and thoughts about these vital services to the community. How your agency and job meet community and your personal expectations of services to substance abusing women will be explored. These questions will require you to answer in your own words with the opportunity to express any concerns you may have. What you say will be written down and recorded on audio tape. There are no right, wrong answers or "trick" questions.

Please be assured that any information you provide will be held in strict confidence by the researchers. At no time

will your name be recorded along with your responses. This exploratory data will be reported in group form only. At the conclusion of this study, you may receive a report on the results from Susan Lacey or Willem Vanderpauwert.

Please understand that your participation in this research project is totally voluntary and you are free to withdraw at any time during this study without penalty, and to remove any data during this study.

I acknowledge that I have been informed of, and understand the nature and purpose of this study and I freely consent to participate. I acknowledge that I am at least 18 years of age.

Participant's Signature

Date

Researcher's Signature

Date

APPENDIX C

Debriefing Statement

The co-researchers Susan Lacey and Bill Vanderpauwert, want to express their appreciation for your participation in this exploratory study. As stated before, there were no deceptive or trick questions and there were no right or wrong answers.

All identifying information will be removed, and you will be assigned a number instead. No individual information will be reported, but data will be analyzed and reported as a group.

The focus of this project are the services provided to substance abusing women and their children, and in particular the perspectives of administrators and the direct services provider. Providers or services are generally not surveyed about their personal views so much as their programs and service delivery are evaluated and researched according to client success.

If you have any further questions regarding this research you may call the researchers, Susan Lacey at (909)945-3733, Bill Vanderpauwert at (909)383-2086 or their research advisor Dr. Marjorie Hunt, California State University, San Bernardino, (909)880-5496.

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